INITIAL APPLICATION

California Licentiate Supervisor and Operator Permits

Last Name, suffix	First Name		Middle Name
Date of Birth	Social Security Number		Phone Number
Mailing Address			E-mail Address
City		State	ZIP Code

It is very important that you provide your full true name.

Pursuant to the authority found in Section 114870 of the California Health and Safety Code and as required by Section 17520 of the California Family Code, providing the social security number is mandatory. The social security number will be used for purposes of identification. The information on this form may be provided to federal, state, or local agencies for law enforcement purposes. This information may also be provided to the American Registry of Radiologic Technologist for examination purposes. For information or access to your records, contact the Chief of the Certification Unit at the California Department of Health Services, Radiologic Health Branch, MS 7610, P.O. Box 997414, Sacramento, CA 95899-7414, (916) 327-5106.

Check the permit category you are applying for:

- ☐ Fluoroscopy Supervisor and Operator Permit.
- ☐ Radiography Supervisor and Operator Permit.
- ☐ Dermatology Supervisor and Operator Permit.

Include with this application:

- ☐ Your nonrefundable **application fee** payment in the form of a check or money order made payable to "**CDHS-RHB**" *(California Department of Health Services – Radiologic Health Branch)* for **each permit category applied for**:
  - ☐ **$85.00** if you are applying for one permit.
  - ☐ **$170.00** if you are applying for two permits.
- ☐ A separate payment for **testing fees** in the amount of **$250** for one permit examination, or **$500** for two permit examinations, in the form of a cashier's check or money order, payable to the "**American Registry of Radiologic Technologists."** *(Personal checks will not be accepted.)*
- ☐ Evidence that you have one of the following valid California healing arts licenses: Physician and Surgeon, Osteopathic Physician and Surgeon, Podiatrist, or Chiropractor.

Return this form along with payments and a copy of your California healing arts licenses to:

Billing and Cashiering Unit
California Department of Health Services
Radiologic Health Branch, MS 7610
P.O. Box 997414
Sacramento, CA 95899-7414

I certify that all information provided with this application is true and correct. I understand that the California Department of Health Services may cancel permits that are procured by fraud, misrepresentation, or mistake, and may revoke permits for the nonpayment of fees. Further, I am aware that it is unlawful to use X-rays on human beings in this state unless I am permitted pursuant to the Radiologic Technology Act and I am acting within the scope of that permit.

Signature	Date